

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035587

STATE FILE NUMBER 1124  
1524

FILED OCT 27 1958 Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1524

300  
1-57

Grant

All diseases in Part I must be causally related. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hosp.		Length of stay in lb 40 yrs.	
3. NAME OF DECEASED (Type or print) Dulcie		4. DATE OF DEATH Oct. 20, 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) unknown
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Theodore Tremmel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 491-09-9441D	17. INFORMANT Mrs. Jean Osborn, St. Joseph, Missouri
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Hypertensive arteriosclerotic cardiovascular disease DUE TO (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 10 hr. 10 hrs + years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year o.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from 10-19-58 to 10-20-58 and last saw her alive on 10-20-58		20f. CITY, TOWN, OR LOCATION 10-19-58 10-20-58 10-20-58	
22a. SIGNATURE Dr. C. S. Grant (Degree or title)		22b. ADDRESS St. Joseph, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE Oct. 22, 1958	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) St. Joseph, Missouri	
24. FUNERAL DIRECTOR Mrs. Clack Handell		25. DATE RECD. BY LOCAL REG. Oct. 22, 1958	
26. REGISTRAR'S SIGNATURE Mrs. Clack Handell			

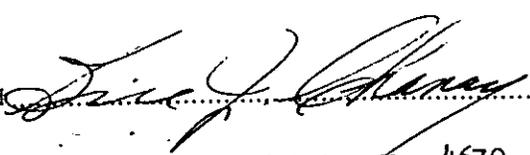
Dr. C. S. Grant

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer .....

Signed  .....

Licensed Embalmer No. 4679 .....

P. O. Address St. Joseph, Missouri .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.